

Viral Hepatitis Case Report

Acute Hepatitis B

Michigan Department of Community Health

Communicable Disease Division

Investigation Information					
Investigation ID	Onset Date <i>mm/dd/yyyy</i>	Diagnosis Date <i>mm/dd/yyyy</i>	Referral Date <i>mm/dd/yyyy</i>	Case Entry Date <i>mm/dd/yyyy</i> 06/27/2014	Case Completion Date <i>mm/dd/yyyy</i>
Investigation Status NEW			Case Status <input type="radio"/> Confirmed <input type="radio"/> Not a Case <input type="radio"/> Probable <input type="radio"/> Suspect <input type="radio"/> Unknown		
Patient Status	Patient Status Date <i>mm/dd/yyyy</i> 06/27/2014	Part of an outbreak?	Outbreak Name	Case Updated Date <i>mm/dd/yyyy</i> 06/27/2014	
Patient Information					
Patient ID	First	Last	Middle		
Street Address					
City	County	State	Zip		
Home Phone ###-###-####	Ext.	Other Phone ###-###-####	Ext.		
Parent/Guardian (required if under 18)					
First		Last		Middle	
Demographics					
Sex <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Unknown	Date of Birth <i>mm/dd/yyyy</i>	Age	Age Units <input type="radio"/> Days <input type="radio"/> Months <input type="radio"/> Years		
Race (Check all that apply) <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify)					
Hispanic Ethnicity <input type="radio"/> Hispanic/Latino <input type="radio"/> Non-Hispanic/Latino <input type="radio"/> Unknown			Arab Ethnicity <input type="radio"/> Arab <input type="radio"/> Non-Arab <input type="radio"/> Unknown		
Worksites/School			Occupations/Grade		
Referral Information					
Person Providing Referral					
First	Last	Phone ###-###-####	Ext.	Email	

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Referral Information cont.*Primary Physician*

First

Last

Phone

###-###-####

Ext.

Email

Street Address

City

County

State

Zip

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Hospital Information															
Patient Hospitalized <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Hospital _____	Hospital City _____	Hospital Record No. _____												
Admission Date mm/dd/yyyy _____	Discharge Date mm/dd/yyyy _____	Days Hospitalized _____													
Clinical Information and Patient History															
Place of Birth: <input type="radio"/> USA <input type="radio"/> Other _____	Did the patient die from hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the date of death: mm/dd/yyyy _____	Was the patient aware they had viral hepatitis prior to lab testing? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown												
Does the patient have a provider of care for hepatitis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Does the patient have diabetes? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Diabetes Diagnosis Date: mm/dd/yyyy _____												
Reason for Testing: (Check all that apply) <table border="0"><tr><td><input type="checkbox"/> Year of birth (1945-1965)</td><td><input type="checkbox"/> Evaluation of elevated liver enzymes</td></tr><tr><td><input type="checkbox"/> Symptoms of acute hepatitis</td><td><input type="checkbox"/> Blood / Organ donor screening</td></tr><tr><td><input type="checkbox"/> Screening of asymptomatic patient with reported risk factors</td><td><input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis</td></tr><tr><td><input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)</td><td><input type="checkbox"/> Unknown</td></tr><tr><td><input type="checkbox"/> Prenatal screening</td><td></td></tr><tr><td><input type="checkbox"/> Other _____</td><td></td></tr></table>				<input type="checkbox"/> Year of birth (1945-1965)	<input type="checkbox"/> Evaluation of elevated liver enzymes	<input type="checkbox"/> Symptoms of acute hepatitis	<input type="checkbox"/> Blood / Organ donor screening	<input type="checkbox"/> Screening of asymptomatic patient with reported risk factors	<input type="checkbox"/> Follow-up testing for previous marker of viral hepatitis	<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prenatal screening		<input type="checkbox"/> Other _____	
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<input type="checkbox"/> Screening of asymptomatic patient with no risk factors (e.g., patient requested)	<input type="checkbox"/> Unknown														
<input type="checkbox"/> Prenatal screening															
<input type="checkbox"/> Other _____															
Is the patient symptomatic? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient jaundiced? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Is or was the patient pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	If yes, specify the due or delivery date: mm/dd/yyyy _____												
Diagnosis: (Check all that apply) <table border="0"><tr><td><input type="checkbox"/> Acute hepatitis A</td><td><input type="checkbox"/> Acute hepatitis B</td><td><input type="checkbox"/> Acute hepatitis C</td></tr><tr><td><input type="checkbox"/> Acute hepatitis E</td><td><input type="checkbox"/> Chronic HBV infection</td><td><input type="checkbox"/> HCV infection (chronic or resolved)</td></tr><tr><td><input type="checkbox"/> Acute non-ABCD hepatitis</td><td><input type="checkbox"/> Perinatal HBV infection</td><td><input type="checkbox"/> Hepatitis Delta (co- or super-infection)</td></tr></table>				<input type="checkbox"/> Acute hepatitis A	<input type="checkbox"/> Acute hepatitis B	<input type="checkbox"/> Acute hepatitis C	<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> HCV infection (chronic or resolved)	<input type="checkbox"/> Acute non-ABCD hepatitis	<input type="checkbox"/> Perinatal HBV infection	<input type="checkbox"/> Hepatitis Delta (co- or super-infection)			
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<input type="checkbox"/> Acute hepatitis E	<input type="checkbox"/> Chronic HBV infection	<input type="checkbox"/> HCV infection (chronic or resolved)													
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Diagnostic Tests

Test Name	Result	Date	
	(P=Positive N=Negative UNK=Unknown)	mm/dd/yyyy	
Hepatitis A			
Total antibody, hepatitis A virus [total anti-HAV]			
IgM antibody to hepatitis A virus [IgM anti-HAV]			
Hepatitis B			
Hepatitis B surface antigen [HBsAg]			
Total antibody, hepatitis B core antigen [Total anti-HBc]			
IgM antibody to hepatitis B core antigen [IgM anti-HBc]			
Nucleic Acid Testing for hepatitis B [HBV NAT]			
Hepatitis B Virus DNA Quantitative by PCR			
Hepatitis B virus DNA Qualitative by PCR			
Antibody to the hepatitis B surface antigen [anti-HBs]			
Hepatitis B e antigen [HBeAg]			
Antibody to hepatitis B e antigen [HBeAb or anti-HBe]			
Hepatitis B Virus Genotype			
Hepatitis B Virus Drug Resistant			
Hepatitis C			
Antibody to hepatitis C virus [anti-HCV]			
Anti-HCV signal to cut-off ratio			
Supplemental anti-HCV assay [e.g., RIBA]			
HCV RNA [e.g., PCR]			
Quantitative Hepatitis C RT-PCR			
Qualitative Hepatitis C RT-PCR			
Hepatitis C Virus Genotype			
Hepatitis D			
Antibody to hepatitis D virus [anti-HDV]			
Hepatitis E			
Antibody to hepatitis E virus [IgM anti-HEV]			
IgG hepatitis E antibody [IgG anti-HEV]			
Other			
Interleukin-28			
Biopsy			
Fibroscan			
Liver Enzyme Levels at Time of Diagnosis			
Test Name	Result	Upper Limit Normal	Date of Result
			(mm/dd/yyyy)
ALT (SGPT)			
AST (SGOT)			

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Epidemiologic Information

Please answer the following questions for the time period 6 weeks - 6 months prior to the onset of symptoms:

Was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, type of contact Sexual <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Household (Non-sexual) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Other _____			
Did the patient inject drugs not prescribed by a doctor? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				Did the patient use street drugs, but not inject? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Did the patient undergo hemodialysis? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Did the patient receive blood or blood products (transfusion)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, when? mm/dd/yyyy _____		Did the patient receive any IV infusions and/or injections in the outpatient setting? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Did the patient have other exposure to someone else's blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, specify: _____			
Was the patient employed in a medical or dental field involving direct contact with human blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, frequency of direct blood contact: <input type="radio"/> Frequent (several times weekly) <input type="radio"/> Infrequent			
Was the patient employed as a public safety worker (fire fighter, law enforcement or correctional officer) having direct contact with human blood? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, frequency of direct blood contact: <input type="radio"/> Frequent (several times weekly) <input type="radio"/> Infrequent			
Did the patient receive a tattoo? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, where was the tattooing performed? (Check all that apply) <input type="checkbox"/> Commercial parlor/shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Other (specify) _____			
Did the patient have any part of their body pierced (other than ear)? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, where was the piercing performed? (Check all that apply) <input type="checkbox"/> Commercial parlor/shop <input type="checkbox"/> Correctional facility <input type="checkbox"/> Other (specify) _____			
Did the patient have dental work or oral surgery? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Did the patient have surgery? (other than oral surgery) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Was the patient hospitalized? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Was the patient a resident of a long term care facility? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown							
Was the patient incarcerated for longer than 24 hours? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown				If yes, what type of facility? (Check all that apply) Jail <input type="radio"/> Yes <input type="radio"/> No Juvenile facility <input type="radio"/> Yes <input type="radio"/> No Prison <input type="radio"/> Yes <input type="radio"/> No			
During his/her lifetime, was the patient EVER incarcerated for longer than 6 months? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, what year was the most recent incarceration? yyyy _____		If yes, for how long? (months) _____			
Did patient have a negative HBsAg test within 6 months prior to positive test? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown							
Verified test date: mm/dd/yyyy _____		Was the patient tested for hepatitis D? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		Did patient have a co-infection with hepatitis D? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			
Was the patient EVER treated for a sexually transmitted disease? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown		If yes, in what year was the most recent treatment? yyyy _____		What is the sexual preference of the patient? <input type="radio"/> Heterosexual <input type="radio"/> Homosexual <input type="radio"/> Bisexual <input type="radio"/> Unknown			
In the 6 months prior to symptom onset, how many male sex partners did the patient have? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2-5 <input type="radio"/> >5 <input type="radio"/> Unknown				In the 6 months prior to symptom onset, how many female sex partners did the patient have? <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2-5 <input type="radio"/> >5 <input type="radio"/> Unknown			

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Vaccine History

Did the patient ever receive hepatitis B vaccine? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown			If yes, how many shots? <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 or more			In what year was the last shot received? yyyy <input type="text"/>					
Was the patient tested for antibody to HBsAg (anti-HBs) within 1-2 months after the last dose? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown						If yes, was the serum anti-HBs \geq 10mIU/ml? (answer 'yes' if the laboratory result was reported as 'positive' or 'reactive') <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown					

[illegible]

Case ID	First Name	Last Name	Viral Hepatitis Case Report	Page 8
Other Information				
Local 1		Local 2		
Name of Person interviewed	Relationship to patient	Date of interview mm/dd/yyyy		
Submitted by:	Date mm/dd/yyyy	Health Department	Phone Number ###-###-####	Ext.

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Other Information cont.				
Comments or Additional Information				

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Case Notes

Notes